



**ACTIVE EMPLOYEES MEDICAL PLAN  
GROUP HEALTH OPTIONS POINT-OF-SERVICE  
CALENDAR YEAR 2006**

BENEFITS	 <b>Point-of-Service 2006</b>
<b>Annual Out-of-Pocket Maximum</b>	<i>In Network:</i> \$1,000/\$2,000 <i>Out-of-Network:</i> \$2,500/\$5,000
<b>Deductible – In-Network Deductible – Out-of-Network</b>	<i>In Network:</i> \$100/\$200 <i>Out-of-Network:</i> \$200/ \$400 (Deductible included in out-of-pocket limit.)
<b>Coinsurance – In Network Coinsurance – Out-of-Network</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%
<b>Office Visit/Urgent Care</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%
<b>Preventive care</b>	<i>In Network:</i> Covered in full. <i>Out-of-Network:</i> Covered up to \$150.
<b>Lab &amp; X-Ray Services</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%
<b>Chiropractic Care</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30% Visits: 20 per year
<b>Prescription Drugs</b>	<i>In Network:</i> Retail: \$15 Generic/\$30 Brand 30-day supply  Mail-order: \$30 Generic/\$60 Brand 90-day supply- not subject to deductible. Subject to formulary <i>Allergy Serum – Covered in full</i> <i>Out-of-Network:</i> \$20 Generic/\$35 Brand - not subject to deductible. 30-day supply
<b>Inpatient Hospital</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%
<b>Outpatient Hospital</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%
<b>Maternity Services</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%


Note: Deductibles apply to all services unless otherwise stated or Plan does not have a deductible. This is a brief Comparison only; not the contract. For more detailed information, please refer to the Summary Plan Description (SPD).

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<b>BENEFITS</b>	 <b>GroupHealth OPTIONS, INC.</b> <b>Point-of-Service 2006</b>
<b>Emergency Room Care (Hospital)</b>	<i>In and Out-of-Network:</i> \$75 co-pay, plus 80%/20%
<b>Ambulance</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 80%/20% Not subject to Deductible.
<b>Durable Medical Equipment &amp; Supplies</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 80%/20%
<b>Rehabilitation Services</b>	<i>In Network:</i> <u>Outpatient:</u> 80%/20% Visits: 60 visits per condition per year <u>Inpatient:</u> 80%/20% Visits: 60 <u>days</u> per condition per year  <i>Out-of-Network:</i> <u>Outpatient</u> 70%/30% Visits: 60 visits per condition per year  <u>Inpatient:</u> 70%/30% Visits: 60 <u>days</u> per condition per year
<b>Mental Health Services</b>  <u>Outpatient</u>  -----  <u>Inpatient</u>	<i>In Network:</i> 80%/20% Visits: 20 visit limit <i>Out-of-Network:</i> 70%/30% Visits: 20 visit limit  ----- <i>In Network:</i> 80%/20% up to 12 days <i>Out-of-Network:</i> 70%/30% up to 12 days
<b>Chemical Dependency</b>	<i>In Network:</i> 80%/20% <i>Out-of-Network:</i> 70%/30%
<b>Vision Exam</b>	<i>In Network:</i> Covered in full <i>Out-of-Network:</i> Covered up to \$50 annually. Routine eye exam every 12 months. Not subject to deductible.
<b>Optical Hardware</b>	Covered up to \$150 once every 24 months per member.

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CALENDAR YEAR 2006**

<b>BENEFITS</b>			
	<b>POINT-OF-SERVICE 2006</b>		
<b>Employee, only</b>	<b>Weekly</b>	<b>Bi-Weekly</b>	<b>Monthly</b>
<b>Employee + one</b>	<b>\$ 12.14</b>	<b>\$ 24.28</b>	<b>\$ 52.60</b>
<b>Employee + more than one</b>	<b>\$ 22.21</b>	<b>\$ 44.43</b>	<b>\$ 96.26</b>
	<b>\$ 37.26</b>	<b>\$ 74.53</b>	<b>\$ 161.48</b>
<b>HEWT Cost</b>	<b>Actual Cost Less Contribution</b>		
<b>Employee, only</b>			<b>\$ 323.12</b>
<b>Employee + one</b>			<b>\$ 591.31</b>
<b>Employee + more than one</b>			<b>\$ 991.98</b>

Employee 2006 cost shares are based on 14% of the actual premium rates in 2006.

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